THE MEDICAL FORTNIGHTLY

Vol. XXXV ST. LOUIS, MONDAY, MAY 10, 1909. No. 9

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LEADING ARTICLES

TOURING THE LANDS WHERE MEDICAL SCIENCE EVOLVED.

FOURTH PAPER.*

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[FOR THE MEDICAL FORTNIGHTLY.]

IBERIA AND LUSITANIA.

MUCH as medical science owes to the crusades, and great as is its debt to the renaissance, it could not have reached its present altitude but for the discovery of America. Had Christopher Columbus failed in his venture we would have had no voyage of the Beagle, no explorations of South America and the Pacific Islands by Darwin, no studies of the fauna and flora of Netherlands India by Wallace, and no deep sea researches of the Challenger. Take these away and what would happen to our modern doctrine of Evolution, how much would we know of the causes of adaptations, and where would we stand in relation to modern biology, with its physiology, bacteriology, protozoology, pathology, and principles of immunity? To the mind unaccustomed to tracing historical effects to their causes it would probably appear as if we could have had all of the latter without the former, but, to one who with a scientific bent of mind insists on knowing why things are as they are, the answer is obvious. Had there been no Columbus we could have had no cinchona or quinin, no erythroxylon or cocain, and none of the other remedies that this new continent has added to our materia medica. Nor could we have had india rubber for the multitude of uses to which it is being put by surgeons, gynecologists, and general practitioners If we inquire why Columbus dared to make so hazardous a voyage and why Ferdinand and Isabella finally consented to risk their money on such a venture we will discover that it was because it was deemed a paying investment from the view points of commerce and conquest. If we ask regarding the character of the commerce that acted as a tempting bait we learn that it was spices, balsams, antiseptic gums and just such goods as were required by the medical men of those times. If we ask for the names of those who made such a voyage possible at that time, we will learn that the venture would have been an insanely hopeless one, but for the astrolobe invented by the two physicians of John II of Portugal. By its aid, for the first time in the history of the world, it became possible for sea-faring men to tell their latitudes and longitudes when far out of sight of land. The world remembers Columbus but forgets Drs. Roderigo and Joseph, without whom Columbus would not have been heard of in our day. If we ask who it was who supplied Columbus with the chart of the earth which he used in order to guide himself, the chart he used in order to convince Ferdinand, Isabella and the friends secured at their court, of the truthfulness of his speculations, we learn that it was drawn by Dr. Paola Toscanelli, a Florentine physician, from the few really scientific facts known at that time. If we ask who it was that came to the rescue of Columbus' theory, when the royal junta had given what was to have been a final and irrevocable decision against Columbus, we learn that it was the scientific friend and councilor of the former father confessor of Queen Isabella, at the convent of Santa Maria de Rabida. Had Dr. Garcia Fernindaz, of Palos, refused at that time to strengthen the convictions of the head of that monastery there is little likelihood that Columbus would ever have

*The first chapter of this series of letters, "Grecian," appeared in the Medical Fortnightly, issue of October 10, 1908; the second chapter, "Christian and Saracen." appeared January 11, 1909; the third, "Medieval and Renaissant," appeared March 10, 1909.

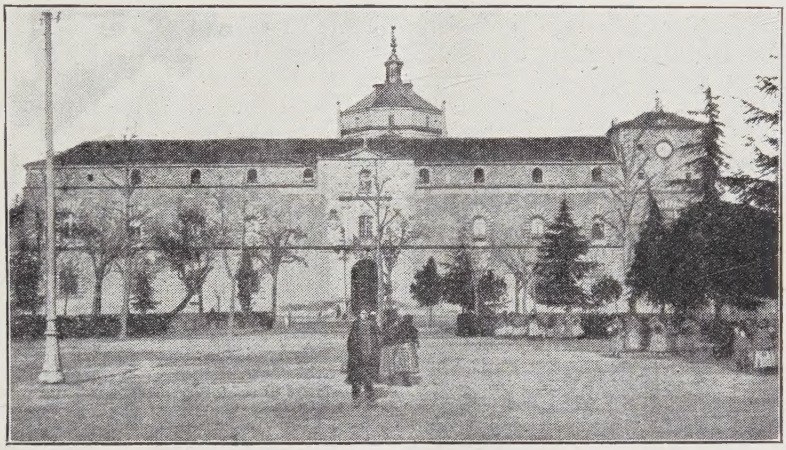
sailed in the Santa Maria, which was named from it.

In order to fully appreciate the motive that led to the daring act of Columbus, let the reader go with me, in imagination, to Genoa, the city in which Columbus was born. Our trip, however, must predate the birth of the great navigator by over a century. We will visit the prison of that city in 1299. Within one of the dungeon cells we will discover a prisoner of war on whose words were hanging the destinies of millions of human beings yet unborn. During the year 1298 the commercial rivalry of Genoa and Venice had reached such a point of angry fervor that fleets from the two cities met in mortal combat. Genoa won and took 7,000 Venetians as prisoners of war. The hero of our story was one of these prisoners. In order to pass the dreary nights and days of a year's incarceration he recited to a fellow-prisoner some of the principal events of his life. The listener being captivated by the narrative, and being a good penman, committed each day's portion of the story to paper. When they were freed this record was published and it was to it, more than any other single circumstance, that Columbus owed his success. From the facts of this narrative Dr. Toscanelli was able to construct the chart which Columbus used. It was the implicit faith which the Spaniards had in this narrative that made the proposed voyage seem so alluring. It presented to their imagination visions of wealth for Spain beyond the wish of avarice. The Venetian prisoner was the now celebrated Marco Polo and the narrative his tale of the wealth and splendor of the countries of far eastern Asia. Venice had become immensely wealthy through its importations of spices and Asiatic gums. Alexandria had waxed rich on the duties it exacted from Venice for letting these goods pass through Egypt. The Pope had given to Christian countries full ownership in all heathen lands that they discovered and started to Christianize. In that day this meant the same to the people of Europe that a guarantee deed to a city lot now means to an American. To reach eastern Asia by sailing to the west meant the securing of immense land possessions and the ownership of these lands meant the taking from Venice and Alexandria their commercial supremacy. The one great doubt of those not swayed by religious tradition was regarding the ability of Columbus to cross the unknown seas. Spain held him, under driblets of pay, for many years in order to keep him from going to some other country and making the same offer to another king. Fearing to make the venture itself it, nevertheless, feared still more the possibility of another country doing the thing it hesitated to do. When, at last, Ferdinand was about to accept the offer of Columbus, his courtiers objected to Columbus demand that he be made governor of the discovered regions. This was proof that they had a strong suspicion that Columbus was right and that he would, by such an arrangement, become greater than the greatest of themselves. And all this was due to their belief in the prison-written narrative of Marco Polo. But this was over a hundred years later than the writing of that narrative. Much had been learned during that hundred years and that much all went to confirm the strange story of the Florentine prisoner. The great Moorish traveller, Mohammed Ibn Batuta, followed by others as daring, had seen much of what Polo saw and returned to confirm the prison-written tale. Importers had pushed their way into these same regions and rapidly became wealthy by the trade they secured. But, alas, for poor Marco Polo. The story he told proved to be his undoing. His fellow-citizens stamped him as the most incorrigible liar that ever set foot in a Venetian gondola. Not until he was long dead did people begin to believe him. He was nicknamed "Marco Millioni," meaning Mark the thousand-fold liar. The court that faced his home bore, for generations, the uncomplimentary title of "Corte del Millioni," or place of the superb liar. Long after his death Venetian comedians appeared upon the stage under the name of "Marco Millioni" and amused the crowds with Munchausen stories. By a freak of fate, if not by design, the site of his home is now occupied by the Malibran Theatre. It is within five hundred feet of the well-known Rialto.

In order to follow Columbus during the many trying years of his sojourn in Spain, and in order to get some idea of the part played by the Spanish in the evolution of medical science, we spent five strenuou weeks of unbroken travel in the land of the Cid. We entered Spain from France by way of San Sebastian. We intended turning aside at Bayonne in order to visit the celebrated shrine at Lourdes, but being behind in our itinerary had to abandon the idea. This remnant of the dark ages, existing near the border of Spain, would have made a fitting contrast to the better elements of Spanish medical practice. While we missed Lourdes we did not miss Burgos or Monserrat. Burgos has a cathedral that transcends the power of my pen to describe. Its architectural beauty has been referred to as the perfection of petrified religion. Its wealth of

polished and carved woods and precious stones is worth more than a king's ransom. its beauty is the very best of an age of architectural beauty. Its altars, its chapels, its cloisters, are sadly disfigured by a needless display of votive offerings that tell of abject medical superstition on the part of the people. Every available spot is hung over with beads, crosses, scapulars, and wax images of maimed and distorted hands, feet, fingers, toes, heads, legs, bodies, etc. The entire human anatomy seems to be represented in dissected sections. These were hung up by the ailing, or their friends, under the delusive hope that the saint to whom the spot is dedicated will cure them of the ailment of which the offering is a symbol. After seeing these we could no longer conceivable way to please us, but we were not Spaniards and could not enjoy Spanish cooking. As Spaniards never eat butter the sole supply is the canned article, that is imported from Denmark for the special benefit of foreigners like ourselves.

As in Burgos, so also on Monserrat, we found a cathedral that was a veritable museum of wax models of deformed limbs, rosaries, pieces of garments, and other votive offerings of the sick. For ages this has been the rendevouz of kings, queens, princes, dons, and of the general public, when in search of health and religious consolation. Offerings of many kinds are made here to the image of Muestra Senora de Monserrat. There probably is not on the whole earth another spot of equal size that



MEDICAL HOSPITAL, TOLEDO.

wonder at the adoration of the average Spaniard for that prince of hypocrites, his "all adorable, wonderful, most excellent, grandest, most magnificent champion"—the Cid. It takes ignorance to see great qualities in such a character. As Burgos was the home of the Cid we visited the place where he was buried. The climb gave us an excellent appetite for our dinners, but this first dinner in interior Spain will long be remembered. We could eat nothing that was placed before us. Everything *looked* appetizing. There was fish, flesh, fowl, eggs, potatoes and pastry in abundance. The bread was like sailor's "hard-tack" and sour. Every article placed before us was flavored with a nauseous combination of garlic and olive oil. Every tourist has this to face whenever he leaves the frontier cities or the capital. We asked for butter and a tin can of the article was laid before us. About fifty per cent of its weight was salt and it looked like so much axle grease. Our host tried every possesses so varied a series of attractions for an intelligent tourist. The mountain, like that of Fusiyama, in Japan, dominates the scenery for many miles of country, because of its lonely majesty. Its weather-beaten crags have no equal for weird, grotesque nature-sculpture. This, the Mountain of the Holy Grail, is a most fitting place for a religious romance like that of Parsifal. There is woven around it such a wealth of legend, and fascinating history, that one could spend months in studying it all. Its paths, monuments, ecclesiastical buidings, rich verdure, immense, highly colored precipices, deep gorges, and strangely costumed monks, make it well worth a long journey to see. As the funicular railway slowly lifts the tourist toward the monastery and as he looks far down to the valley below, he is reminded very much of the view of the Grand Canon of the Colorado from Hance's Trail. Within sight of the monastery is the cavern in which Ignatius Loyola spent nearly a year

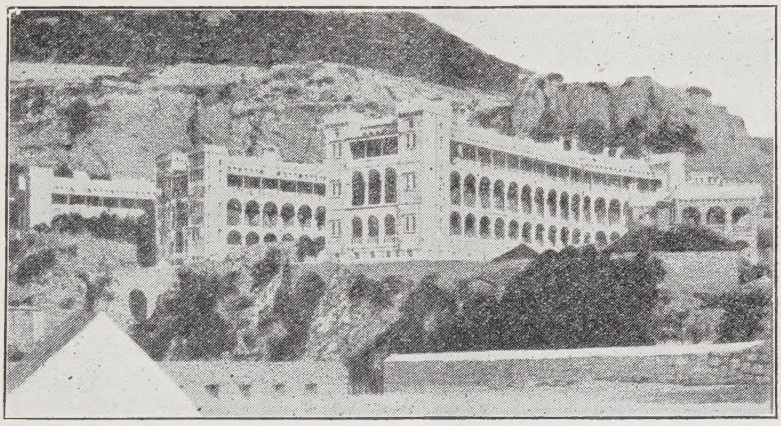
of self-abnegation preparing himself for his misson of founding the Society of Jesus, now better known as the order of Jesuits. In front of the image of the virgin, in the chapel of the monastery, he made his vow of consecration. It was his priests who, in later years, gave to the world its first organic specific remedy against disease. They were the first white men—and perhaps the first human beings—to cure malarial fever. They supplied to the Countess of Cinchon the bark that cured her of an attack of this disease. It now bears her name because she had the first supply of it sent to Europe. For generations before quinine had been extracted from it the popular name was Jesuits' bark or Jesuits' powder. The Jesuit priests imported great quantities of it to Europe, charged large prices for it, and helped maintain their foreign missions thereby. The medical profession fought against its use. The Paris faculty, and professors of therapeutics generally, heaped all the abuse upon it that they could. As late as 1792, Dr. Kanold, a leading physician of Breslau, permitted himself to die of a pernicious quartant fever, declaring the while that he would rather die than use the "quack" drug. Such independent reasoners as Sydenham, Peyer, Albertini, and Torti, refused to follow the lead of conservatives, and so tried it. But for these men the profession would soon have been disgraced. The ostracised Paracelsus did not hesitate in advising his followers to try it. But for the dogged determination of this man we would have had no laudunum for pain and no mercury for syphilis. He taught in Basle, Switzerland.

Here we are reminded that the introduction of syphilis into Europe seems to have occurred soon after the discovery of America and may have been brought by the Spanish sailors. What knowledge of disease we may have acquired from this malady we should, probably, credit to Spain.

Monserrat is not far from Barcelona, a beautifully situated city on the shore of the Mediterranean, where every well-to-do citizen vies with every other in the outside decorations of his home. No other city can compare with this for fancifully carved and scene-painted fronts. Money we spend on interior decorations here seems to be spent most lavishly on the outsides of their houses. It was here where Ferdinand and Isabella gave Columbus his royal reception on his return from his first voyage. On the route from San Sebastian to Barcelona there are two points of historic interest to medical tourists. These are Tudela, the birth-place of Michael Servetus and Saragossa, where he acquired his early collegiate education. Later in life he graduated in medicine at Paris where he afterwards succeeded his teacher, the great Vaselius, when the latter removed to Padua. While acting as demonstrator of anatomy his anti-Galenical views and his theological views got him into trouble with the rest of the faculty so that he had to quit Paris. He then practiced his profession, first in Avignon and then in Charlieu. While in Paris he became acquainted with Calvin, the world renowned theologian. They discussed together questions of religion. While Calvin was at his home in Geneva he and Servetus corresponded together. It was these letters to Calvin that fixed the authorship of "Christainismi Restitutio" upon Servetus. Being caught, while on a visit to Geneva, he had to stand trial for heresy, was found guilty, and, on refusing to recant, was burnt at the stake as a heretic. He escaped from the inquisitors of Catholic Spain to suffer death at the hands of the inquisitors of Protestant Switzerland. The blue waters of the beautiful lake of Geneva received his ashes while the smoke from his burning body was wafted toward the snow-capped summit of Mont Blanc. What a horrid sight with which to desecrate so lovely a spot. They asked him to pray: "Jesus thou eternal son of God." He showed his stubborn will in behalf of what he believed to be truth and to the last repeated: "Jesus thou son of the eternal God." Because of the difference in meaning between these two brief sentences he was condemned to die a death that only a savage could devise. The difference is so subtle that many are unable to grasp it. But to the medical man the volume that brought him to the stake is of peculiar interest. It contained the earliest, non-Grecian statement of the circulation of the blood. It lacked the perfection which Harvey gave to that doctrine, at a later date, but it was a wonderful anticipation of the same. As Servetus died in 1553 and Harvey was not born until 1578 the relationship is apparent. Our double interest in Servetus as philosoper and medical man determined us to make a stop at Saragossa. The Spanish pronounce it Thar-Agatha, and it is a corruption of Ceaser-Agustus for whom it was formerly named. We happened there at the "fiesta" of the "Virgin del Pilar." The city was crowded with pilgrims dressed in the most fantastic of holiday attire. Strange shaped hats, many-colored mantillas, immense leather belts, jewelry that a Hindoo would have envied, stilletas innumerable, and donkeys of many sizes appeared everywhere. Until we saw those costumes we deemed stage representations of Spanish life exag-

gerations. Now we know they are not. Many a Sancho Panza could be seen riding his donkey among the crowd with here and there a Don Quixote on horseback. In the latter the saddles, bridles, stirrups, and spurs, were fearfully and wonderfully made. A rich lady's trousseau could scarcely display more expensive work. We visited the del Pilar Cathedral and were guided through its chapels and aisles by one of its priests. The edifice is believed to be built on the exact spot where, about 1900 years ago, the Virgin Mary appeared to St. James. The pillar on which she stood occupies the center of the cathedral, and is polished and worn into a most fantastic shape by the lips of many centuries of kissers. An image of the Virgin now surmounts this pillar and to it pose his "Il Trovatore" and nearby was the Castle of the Giants that took us back in memory to our nursery tale of Jack the Giant Killer. There, carved in solid stone, are huge images of the very giants that adorned the pages of our story book.

On leaving Saragossa, as on two other occasions, we experienced the inconveniences of Spanish methods of conducting railways. It is a rare thing for an express to travel by daylight and only happens when the distance gone requires more than twelve hours. They are usually corridor sleeping cars. Unless the passenger secures his berth a day in advance none can be bought. Every berth is, as a rule, occupied. The company will not put on a car which they are not morally certain will be full. At any way



MILITARY HOSPITAL, GIBRALTAR.

the multitude appeal for intercession with Christ and for relief from disease. As we pushed our way among priests, nuns, boys, girls, men, and women all devoutly praying with uplifted hands, or crossing their bodies in the interimssions, we felt almost as if we were guilty of sacrilege and frequently hesitated to proceed. Our priest-guide had no such compunction of conscience and so hurried us along. On gaining the street we saw numerous bevies of "Spain's dark daughters" who did credit to Byron's description of them in Childe Harold. We stood where the Maid of Saragossa, "Hung so fiercely on the flying Gaul, foiled by a woman's hand before a battered wall." When her lover was shot she seized his rifle and re-encouraged the 220 daring men just as they were going to fly. She shamed them into courage and that day they beat back 18,000 French soldiers. Byron has depicted it. From here we proceeded to the interior of the town. There we saw the historic spot which inspired Verdi to com-

stations and crossings the would-be passenger finds the train in which he hoped to proceed, with every car labelled, "Complete." He must either telegraph to the starting station and secure a through berth for the next night, or he must take a slow day train in the morning. If he telegraphs he must pay for the entire distance that the train goes, Some few express trains carry day coaches, and if they are not labelled, "Complete," he can secure a seat in one of these by paying a supplemental fare. These trains are denominated "Rapide," although they never exceed 35 miles per hour. Only first-class tickets, plus a supplementary fare, will be accepted. All time tables give the times of trains on the twenty-four hour day. Strangers must learn what is meant by 18.35 or 19.24 o'clock in order to know when to catch a train. Only sleeping cars have accommodations, like toilets, and as other trains are slow with, sometimes, great distances between stations, and stops of only about five minutes, it is easy to imagine the

condition. If one tries to reach a point other than Madrid, except by going through Madrid, he will find that the long way around is always the quickest way across. No short-cuts are possible on Spanish railways except at the cost of an enormous loss of time. We were compelled to visit Madrid six tims when once should have been enough. It was there that we saw the barbarous, stupid, cruel sport—the bull fight. It is not a sport that requires skill, and when a man is gored it is due to his being off his guard by becoming absent-minded. Horses are gored purposely to excite the stupid crowd. Every move of the bull can be foreseen by any intelligent onlooker. The present queen of Spain does well to discourage such sport(?). We saw her and the king at short range, as their carriage passed near us on a street near the palace. She looks like a very intelligent young woman. The king looks bright but is small in stature so that his appearance is very boyish.

Our visit to Salamanaca was made from Madrid, by way of Medina. The last named place is where Queen Isabella is buried and as it is a junction we had to spend the night there, so that in that way we had a fair opportunity of seeing the girl-home of Isabella, and her last resting place. In order to save a day it was necessary to bribe a railway conductor to let us ride on a box, in the corridor of a "complete" train for a distance of about forty miles. He positively refused to look at any small amount, but finally yielded when he saw the value of five American dollars. To have missed that train would have spoiled our visit to Salamanaca and endangered us of losing an all-night ticket for a sleeper on another line, which we had secured before leaving Madrid. From Medina to Salamanaca is within the ancient Roman province of Lucitania. Madrid, Barcelona, and most other points we visited, are within that of Iberia. On reaching Salamanaca, and wandering through its quaint streets we found it hard to realize that this was a city long before the Christian era. It still shows signs of early Greek connections. Hannibal captured it in 217 B. C. It has had Roman, Goth, Saracen and Christian masters. While in possession of the Moors its University was started and the liberal views that then obtained held it back from the wild fanaticism of the inquisitors. Ferdinand and Isabella asked that the university professors give Columbus a hearing to decide on the practicability of his proposed voyage. The hearing occurred in a nearby convent. He won over the most liberal of the faculty. Every argument that he presented, however, was met by the conservatives pointing to Ezekiel fifth chapter and fifth verse. Every medieval map of the world was made with Jerusalem in the center in order to conform to this text, and most of them had it printed on their margins. When he told them of the strange colored and strange featured men who had been cast up by the tide on the coast of the Canaries, of the strangely carved woods that had been found at the Azores, of the statements of Ptolemy, whom they pretended to accept as a guide in matters of this kind, all they did was to ask him to explain Ezekial's words: "Thus saith the Lord God; this is Jerusalem: I have set it in the midst of the nations." There was no getting around this passage without endangering one's life by the inquisitors. Columbus and his backers could only remain dumb. They dared not discredit holy writ and they could not say that it was Ezekiel's mere opinion. In vain did Columbus quote to them the remarkable and prophetic words of Seneca, where he says: "At a distant date this ancient world will westward stretch its bounds, and then disclose beyond the main a vast, new continent, with realms of wealth and might." In logic the fight was a tie. In numbers the conservatives won, as they always do at first, and so Columbus lost.

Before leaving northern Spain we visited the Escorial, Valladolid, Tarragano, Toledo, and other points of interest. At Valladolid we saw where Columbus died, where Ferdinand and Isabella were married, and where Cervantes lived. At the other points we saw much of interest, but to enumerate them would swell this communication into undue proportions. On reaching Cordova the Moorish mosque—the finest in the world—and the many evidences of former Moorish supremacy, reminded us that this was the birth-place of that prince of Mohammedan physicians Averrhoes. Columbus, too, lived here and probably spent more time here than in other Spanish cities except Seville. Averrhoes had also lived at Seville and was for sometime cadi there. His writings, next to those of Galen, swayed the opinions of the medical men of Europe most. All other medical writers of those times took a subordinate place. Padua, that did so much for medical progress, was the seat and center of Averrhoeism. So long as Averrhoes let theology alone he was honored and respected by his Mohammedan neighbors, but as soon as he ventured into the realm of theology trouble began. The devout ones tried to get him executed, but they only succeeded in getting him degraded. He was driven out of the part of the city occupied by the faithful, had his property confiscated, and on several

occasions was compelled to stand unturbaned, and with tied hands, in front of a mosque when the faithful entered to pray. It was the duty of the latter to spit upon his face, both going and coming, and the small boys were taught to pelt him with dirt and stones. Long after he was dead Erasmus spoke of him as "The impious and thrice accursed Averrhoes." Petrarch refers to him as "A mad dog barking at the church." In Dante's Inferno he is pictured as seated in hades along with Hippocrates, Galen, and Avicenne. Most of his writings, in manuscript form, are being preserved in the library of the Escorial. If Philip II, could have foreseen this he might have ordered that building, that cost him so much, destroyed. As cadi of Seville, Averrhoes never endured the agony that came to Columbus in that city,. It was there that the latter received what was intended to be a last and complete dismissal to his suit from Ferdinand and Isabella. The junta appointed to make a final decision upon the matter definitely pronounced his scheme unworthy the further attention of their majesties. He received the message in despair. He had been held in Spain by Will o' the Wisp promises, during the best part of his life, and to be thus dismissed at last was a staggering blow. Heart-broken he and his little son, Diego, started on foot, for the home of his brother-in-law, at Huelva, fully determined to sail from there to France and leave Spain forever. Tired, hungry, and thirsty they reached the monastery of Santa Maria de Rabida, where they waited for some passing boatman to row them over the Tinta River to Huelva. Columbus begged some bread and water for his boy from one of the monks, and while it was being eaten the prior happened to pass and engaged in conversation with the father. Naturally the conversation turned on where Columbus was going and why he was about to leave Spain. As soon as the prior had taken in the situation he sent to the nearby town of Palos for Dr. Garcia Fernindaz, the scientific man of the place, and Martin Alonzo Pinzon, the richest merchant of the region. As soon as they reached the monastery Columbus again recited his story, gave his theory and the facts he had to substantiate it, after which it was thoroughly discussed by those present. Dr. Fernindaz, seeing the force of the evidence, was an immediate convert and the others promptly accepted his conclusion. Fray Juan Perez de Marchena, the prior, immediately despatched a messenger to Queen Isabella, at Santa Fe, begging an audience with her. As her former father-confessor he felt confident that she would grant it and so he detained Columbus at the monastery till he heard from her. She ordered him to come to her immediately. There he pleaded Columbus' case with her and took back an invitation for Columbus to repair at once to Santa Fe and see her. Even then things did not move unruffled at the royal hearing. The courtiers interfered, on the plea that too much was being asked as a reward in case of success. Finally, however, the matter was settled in favor of Columbus. The Queen offered to pledge her jewels to defray part of the expenses but the treasurer of the exchequer relieved her of having to do so by assuring her that there was enough left, over the war expense, to defray the royal share of the cost of the expedition. Martin Alonzo Pinzon, personally paid for the fitting out of one of the ships and accompanied it as captain. But what a world of trouble they had in securing sailors. It finally became necessary to resort to conscription and compel enough sailors to go. Amid the tears and pleadings of mothers, sisters, and sweethearts they were forced on board by soldiers, after taking the sacrament, and receiving the blessing of the priest, at the Chapel, in Palos. From the Port of Palos, the Santa Maria, Pinta, and Nina, sailed past the monastery of Santa Maria de Rabida, into the Gulf of Cadiz. From the window of the monastery there is an extensive view off into the gulf and from there the Prior, the monks, and Dr. Fernindaz watched the three ships until they had disappeared beyond the horizon. As we looked out of the same window, over 400 years later, we wondered what would have been the condition of the earth, at present, if those three little mites of vessels had perished on their voyage. On what frail threads momentous issues hang. Although most of the romance, pathos, poetry, and prophecy of American greatness hangs over this little hill on the sea-shore few are the Americans who do it the grace of a visit. All they seem to think of is Granada and the Alhambra, the Escorial, and the bull fights. On its summit now stands a large monument to Colon (Columbus) that can be seen for many miles in every direction. Whether the visitor goes thither by sea or by land it is the first thing he sees on passing the horizon, or on leaving the mountains. It seems to beckon to every American and ask him, if only as a duty, that he come and pay his respects to that place which, next to his own home, should be the most important spot in all the world to him. In Palos he will find the same church and the same altar before which Columbus and his crew knelt to receive the benediction of the priest. The wharf is

gone, commerce has gone, and the population has shrivelled into barely four hundred, but its influence must forever remain to bless mankind. We saw Granada, we saw the Alhamba, and all the beautiful things there, which Washingtion Irving's pen-pictures have immortalized, but would far rather have missed seeing them than have missed our visit to Palos and de Rabida. As a small boy at school I had learned to recite the Spanish Champion, and so knew something about the Cid, but Burgos failed to impress us as being any more romatic on account of it. Not so, however, was the effect of our school days lesson concerning hungry little Diego and the good monk who gave him bread and water. The monastery door, where Columbus stopped and knocked, seemed like an old friend to me, although I had never been there before. The grounds around the monastery are now laid out in beautiful garden plots and date palms decorate the central walk. While we were there these hung laden with immense bunches of yellow fruit that added materially to the beauty of the spot. The main room of the monastery, on its upper floor, is hung with historic pictures of interest to Americans. The first shows Columbus in Palos. Provisions are being loaded upon his ships. He is bidding his friends good-bye. Women are weeping over their departing sailor lads. The second shows Columbus discussing his plans within the room where the pictures are hung. Pinzon, the Prior, and Dr. Fernindaz are appealing to a lot of visitors for financial aid to assure the success of the project. The third shows the ships passing de Rabida. On a small boat at the shore Columbus and the Prior are bidding each other good-bye. Columbus is kissing the hand of the Prior. The Fourth shows the first conference of Columbus with Pinzon, Fernindaz, and the Prior, in that room. Diego sits on a chair behind his father and two monks are looking out of the window toward the sea. The fifth shows Columbus and Diego at the monastery gate. The boy is eating the bread that has been given to him. Columbus and the Prior are to the left of the entrance and near the little shrine. The other pictures are chiefly portraits of the actors in these scenes and of the king and queen. From de Rabida we made our way to Gibraltar, via Huelva, Seville, Cadiz, and Tangier, seeing on the way, among other things, the Quemadera where the two fanatical friends, Ximenes and Torquemada, burnt 298 heretics after confiscating their property; where Ferdinand Magellan started on the first fleet the remnant of which circumnavigated the earth; where, by the order of Francisco Bobadilla, Columbus was landed, in chains, after being deported from the West Indies; where the Invincible Armada, of Philip II, started with the intent of conquering England; and Trafalgar Bay where Lord Nelson won his victory over France.

REMOVAL OF AN INTRATHORACIC OSTEO-SARCOMA INVOLVING FIVE RIBS.

J. F. MENISTRINA, M. D.

ST. LOUIS.

At the Dec. 16, 1908, meeting held in this city of the Southern Surgical and Gynecological Association Dr. J. B. Murphy in the course of his paper on the subject of thoracic surgery, boldly made the assertion that no hesitation should be felt in attacking the chest for a pathological condition as well as the abdomen, and predicted the time was near at hand when such procedure would be taken up everywhere by surgoens with comparative safety.

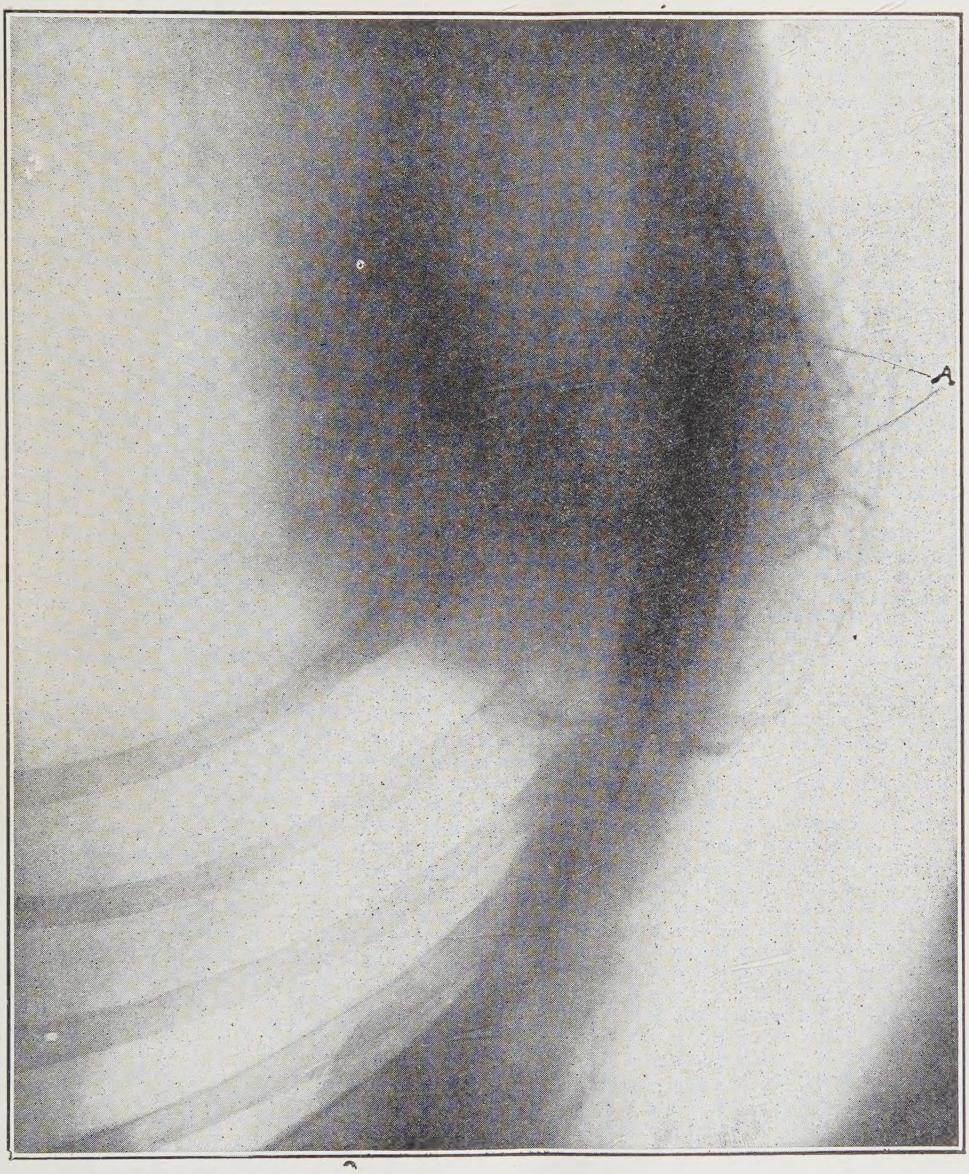
On the same morning prior to his statement and strangely coincident as to the date, the case here reported was operated upon at the Centenary Hospital, and the results obtained certainly corroborated this bold surgical assertion, and I wish to express a regret that the specimen was not presented to him and to the members of the society to substantiate his remarks.

Heretofore malignant tumors of the chest wall, especially those involving the pleura have been seldom attacked. These tumors usually are of traumatic origin springing from a fractured rib and are usually sadly neglected until the tumor takes on a sudden growth. Pain will then surely bring these patients to us when growth is well advanced. It is indeed distressing to the thoughtful physician how most men become solicitous in running to a doctor for the most trivial affection of any of the external organs and pass unattended such a serious condition as this for so long.

When seen these growths having origin either from the skin, such as ephlids, naevi, dermoid or sebaceous cysts, fibroid, lipomas, moles; lymphatic glands, periosteum, cartilage or the bones, such as enchondromata or sarcomata or carcinomata, any of these the surgeon should insist on early removal, owing to the great tendency of the most benign growths to become malignant, before too dense infiltration and involvement may render surgical intervention useless.

The case here reported is one of unusual

interest, showing that while the tumor was so large, involving half of the left surface of the chest wall, penetrating the pleura and showing as much growth on the inside as on the outside, still it was removed rapidly, safely and with comparative ease.



REPORT OF CASE.

L. C., male, age 55, miner, presented himself December 15th, 1908, for relief of pain on the left chest. Examination revealed a firm tumor ranging anteriorly from the sixth rib, one inch to the left and one inch below left mamma extending to the tenth rib. Posteriorly following this rib to the axillary and inferior border of the scapula, it involved the greater portion of the sixth, seventh, eighth and ninth ribs. He gave the history of having sustained a fracture of one of his ribs seven years before while twisting suddenly in his sleep. He was in no great discomfort, however, and worked continuously since. A little callous growth appeared at the site of fracture, but was left unnoticed. About August last this growth began to increase in size rapidly and he suffered intense neuralgic pain, that disabled him from work and made sleep impossible. I directed him at once to Dr. R. D. Carman, for an X-ray examination. The rib that was fractured was clearly seen, also the ex-

tent of intrathoracic and extrathoracic growth.

He was made aware of the extreme danger and complication of his case and of the boldness of the surgical undertaking, but he stoically submited to the ordeal rather than suffer the excruciating pain any longer, he was prepared for the operation, which was done on December 16th.

Operation, Karewsky's method.

An incision was made in the skin over the middle of the tumor. The skin was healthy and loose and not involved. Flaps were cuffed anteriorly over the pectoral muscles and over the scapula posteriorly. Gauze pads protected the skin and made a clean field. The tumor was freed from its surroundings, sacrificing all muscular tissue attached to it. The ribs to which the tumor was adherent were divided subperiosteally, beginning from the sixth to the tenth, an inch to the left and below left mamma to the axillary and lower border of the scapula. The pleura was easily freed from a portion of the tumor, but it was unfortunately a part of it farther in, and it was necessary to excise. Long strips of moist sterile gauze pads were made ready and secured by forceps. The anesthetizer was warned to let the patient come out of deep narcosis as coughing in these cases is always desirable and violent distention of the lungs prevents dangerous pneumothorax. A small primary opening into the pleura was made to allow the air to enter slowly. This was protected at intervals by the gauze pad. This was done to avoid sudden entrance of air through the pleura and consequent collapse of the lung, and to give time for the condition of external and internal pressure to adjust themselves. More gauze pack was introduced in the pleural cavity as the opening was enlarged. The disturbed and violent respiration was very marked for a time, and the patient was exceedingly cyanotic, but luckily it was only of short duration. The tumor was finally delivered. The lung and pericardium were not involved and it was found possible to approximate the cut ends of the pleura by flexing left chest and to suture these with Bartlett catgut No. 2, little by little removing the gauze pads. When the pleura was completely sutured, the surface was inspected. The cut surface of the ribs was still farther stripped back and rongeured to make sure of giving a wide berth to the diseased condition. The skin flap over the pectoralis muscles was still farther stripped up and a section of the pectoralis major was sliced and deflected downward. The same was done with a portion of the latissimus dorsi and where the two met they were sutured. This was necessary to fill existing gap. Skin flaps were brought over these and sutured, leaving a cigarette drain on each end.

The whole procedure was rapid, lasting but thirty minutes, and to this speed I contribute no little the success of the work. He left the table in a very fair condition and suffered little shock. The next day the drains were removed. A little sinus existed for a few days on the posterior edge of the wound, but it finally healed. The lung expended very nicely. He made an uninterrupted recovery.

He was treated for a while with Coley's serum beginning with one-fourth drop dose every third day with the resulting characteristic systemic effect. It was gradually increased to half drop and one drop. He was also given X-ray treatments by Dr. Carman. So far no return of the growth nor any unpleasant symptoms have occurred. He is, I am told, again at work in his occupation of miner.

The tumor was examined by Dr. Vosburgh and found to be an osteo-sarcoma, having its origin from the fractured rib.

Dr. S. Weir Mitchell celebrated in February the eightieth birthday of an unusually rich and productive life. It is given to few men to shine conspicuously in two overcrowded fields of endeavor, yet Dr. Mitchell has won a place in both science and literature that will endure long after he has answered the final call.

Urticaria, eczema and erythema sometimes produce almost intolerable itching of the skin. Various local applications have been used, with more or less success. It is stated on good authority that ten-drop doses of the balsam of copaiba, taken three times a day, will allay the itching in such cases, and prove beneficial in other ways.

Canal Zone Health Report.—The chief sanitary officer of the Canal Zone, in his report for February, announces that the death rate for that month for employes was at the annual rate of 10.98 per 1,000. The death rate for the total population was 18.59 per 1,000, the lowest death rate since the United States has been in charge of the Isthmus. There was also a large diminution the amount of sickness among employes in February as compared with January, the respective daily figures being 951 and 1,116. During January, 1,258 cases of malaria among employes were admitted to the hospital, and during February only 852. No case of yellow fever, plague or smallpox during the month.

STENOSIS OF THE ESOPHAGUS.*

JOHN M. BELL, M. D.

ST. JOSEPH, MO.

THE object of this paper is to call attention to the frequency of stricture of the esophagus, and the necessity of an early diagnosis in obtaining results. It is a lesion lost sight of not because of its obscurity so much, as to indifference to the physical examination.

Stricture at this point exists as a sequel to drinking caustic fluids or very hot innocuous ones. It results from cicatricial contraction of ulcer in the esophagus or in the stomach at the cardia. Carcinoma is a frequent cause, either de novo or from a previously benign lesion becoming malignant. Its frequent occurrence at the cardia (that is carcinoma) may be accounted for from the fact, as suggested by Mayo, of this point being one of the places where food is either halted or squeezes itself through or grinds its way on, as at the sphincters and flexures throughout the digestive tube. The cardia, pylorus, cecum, hepatic flexure and sigmoid are points of election where carcinoma engrafts itself. Food is retained at the cardia from three to seven seconds, and then passes cautiously, as it were, into the stomach. Stenosis is also said to occur idiopathically by Bensuade and Rivet. This seems rather improbable. Most likely the etiological factor in such cases has been lost sight of for two reasons. In the first place contraction does not come on for months, and in children for two or three years afterwards; and secondly, the esophagus is one of the least sensitive structures of the body, even cancer causing no real pain until very late. When well advanced from any cause pain is not a factor; food may be regurgitated, unchanged, or remain in the tube over night and be considered merely belching by the patient, and by the physician be interpreted rumination.

Another form of stenosis is that of cardiospasm, either of purely neurotic origin or like pylorospasm, due to an irritation of remote source (elsewhere in the digestive tube) and aggravated by a neurotic tendency. In this way pylorospasm may arise from appendicular irritation. In this form of stenosis (spasmodic) there is the same diversity of diagnostic findings as in nervous dyspepsia. Here HCl may be absent one day, present the next, excessive one day and diminished the next; so in nervous stenosis at the cardia, at one sitting the tube or sound passes readily while at the next it may show distinct constriction. In almost all cases of stricture this deviation is noted, although if organic lesion be present, the tube never passes easily; the degree of stenosis may vary, but is never absent in organic stricture. The complete lack of it at times is diagnostic of the nervous spasm only. The difficutly of early diagnosis is due to the two factors quoted above, first the length of time elapsing after the injury, be it actual trauma or caustic drinks; second, the absence of pain. The difficulty of swallowing is apt to be attributed to rapid eating and faulty mastication; the vomiting due to gastric disease. Food particles may remain, while liquid pass, or they may remain over night. The differential diagnosis depends upon the lack of all gastric ferments in the vomitus. Retention over night causes cough and general restlessness, as in chronic gastritis. Foul breath comes from decomposition in the tube. Loss of flesh is not noticeable until the constriction becomes so well marked that the amount of food vomited is greater than that which passes. The only hope of early diagnosis dwells in a thorough examination of the whole digestive tube.

In two recent cases quoted below the condition was detected incidentally during the course of the general overhauling to which all gastric cases are subjected, the patients complaining of no esophageal disturbance. The routine examination consists of auscultation and percussion of the thorax for reflected symptoms, palpation and auscultation of the abdomen—freed of all clothing; chemical analysis of stomach contents obtained by means of the tube; examination of the rectum; flushing the colon with massage; and analysis of fecal contents. If the symptomatology suggests it, a microscopic analysis of the cellular elements of the stomach, after twelve hours fasting is also made.

March, 1908, I saw a boy at Hamburg, Iowa, in consultation with Dr. Wanamaker, who had swallowed some washing powder, in solution used for cleaning an old building. The boy recovered from the immediate inflammation of the esophagus and became apparently well. He has remained so for months until a week ago I heard that he was having some difficulty in swallowing. Twelve months have elapsed before dysphagia developed.

In September of last year I was in consultation with Dr. Jacob Geiger, Mr. G., of Nodaway county; a man of 65, who has in a few months lost forty pounds. He complained of indefinite gastric symptoms,

*Read before the St. Joseph Academy of Medicine, April, 1909.

principal among which was vomiting of foodstuffs with much tenaceous mucus. I concurred with the doctor's diagnosis—that of carcinoma of the stomach; the location was not determined. Operative methods were refused and the patient went West. In February he came to consult me to see if something medically could not be done. He was still losing flesh, was weaker and still vomiting. Although he was emaciated palpation revealed no mass in the gastric area. In an attempt to secure the stomach contents for examination by means of the tube, it was found to be impossible on account of cardiac stenosis. The smallest metal sound would not pass, although persisted in for five days, at intervals. Further examination of the vomitus showed absence of all gastric ferments. Constant thirst was complained of and the urinary output fell to 8 ozs. in 24 hours. Gastrostomy was advised as the only possible hope and that not brilliant. It was refused. He returned home and passed away, within three weeks, of starvation; rectal feeding had long since proved of no avail. In this case esophageal disease was not discovered until stenosis was almost absolute, and then only incidentally.

In November, 1908, Mr. E. H., a farmer, aged 28, consulted me for dyspepsia. He had been treating for it three months with no result. Loss of flesh and vomiting were complained of principally, but since these may result from so many digestive complexes, esophageal disease was not thought of by me, nor complained of by the patient. The passage of the stomach tube met with distinct obstruction at the cardia, but finally passed. Subsequent examination of vomitus revealed only large pieces of foodstuff with much ropy esophageal mucus. Lavage was used daily for two weeks and perfect mastication was obtained by taking meals dry. Vomiting ceased, except when rapid eating allowed large particles to be swallowed. Late, dilatation was effected by metallic sounds followed by the lined linen mesh bougie. At the first this was done daily, the intervals gradually increased as symptoms subsided, until now he comes in once a week or ten days only. He has regained his color and flesh, swallows well, sleeps well and has no symptoms. A diagnosis of benign stricture in this case is justifiable. In cases seen late and apparent hopless, Lereche has used filiform bougies to effect dilatation followed by small sounds upon a guide. This is done through the esophascope. Then by means of an esophagatome the stricture is divided, and subsequently dilated at frequent intervals. Complete recoveries are reported. Two French writes have discovered a similar scheme with recovery. This is done under cocaine anesthesia. The difficulty generally reported is the repugnance patients have for the esophagscope. While it has its advantages as a diagnostic agent there is danger of getting into an aneurism or a fistula, both of which give rise to a symptomatology of ordinary stricture. Bearing these possibilities in mind, it is well always to sound new cases with the soft rubber tube, and that without undue force. This is my routine procedure.

Recently N. W. Green and J. W. D. Maury, of New York, have reported operative procedures essentially new. With stricture low down, they have removed the mass and sutured the proximal end to the cardia of the stomach. In another case they have side-tracked the cardiac orifice and made a new opening with a Murphy buttion. These procedures while illustrating the possibilities of esophageal surgery are applicable to selected cases only; the consideration of which is beyond the scope of this paper.

In conclusion, I would reiterate that while stenosis of the esophagus, until late—has little to suggest its existence, when looked for is easily found.

213 North 7th St.

Barber's Itch Ointment.—The following is said to be effective:

℞ Creolin-Pearson fl.3
Oleate mercury .....
Oxide zinc .....aa 3iv
Salicylic acid 3j
Yellow petrolatum 3iss
—Pacific Pharmacist.

Good Catheter Lubricant.—A good formula for a catheter lubricant has the following composition:

℞ Oxycyanide of mercury..... gr. iv
Glycerin 3v
Tragacanth (best quality). gr.xlviij
Aqua dest 3xxv
—St. Louis Med. Rev.

Dry Eczematous Patches on the Skin.—

℞ Acidi salicylici..... 3ss
Bismuthi subnitratis.....
Amyli.....aa 3iiss
Adepis lanae hydrosi..... 3j
M. Sig. Use externally as directed.
—Merck's Archives

Cholera in St. Petersburg.—Up to February 22, when the epidemic of cholera in St. Petersburg had lasted for 160 days, 10,000 cases had been reported with 3,928 deaths. The largest number of new cases reported in one day was 444, the lowest nine.

SURGICAL EPONYMS.*

MARTIN HAGEN, M. D.

CHICAGO, ILL.

Abadie, J.M. Charles (1842-con.), French; ophthalmologist, Paris. Operation, cervical sympathectomy.

Abbe, Robert (1851-con.), American; surgeon, New York. Operation: 1. Posterior cervical sympathectomy. 2. Lateral enterorrhaphy. 3. Esophageal stricturotomy. 4. Hysteropexy.

Abbot, George E. (1852-con.), American; surgeon, Pasadena, Cal. Operation, restoration of loss of substance in finger tip.

Abernethy, John (1764-1831), English; surgeon, London. Operations: 1. Ligation of the external iliac artery. 2. Ligation of the common carotid.

Adams, James A. (— con.), Scotch; surgeon, Glasgow. Operation, see Alquie-Alexander-Adams.

Adams, James J. (1794-1861)? English. Operation, for amaurosis, dysopia and myopia.

Adams, Sir William (1760-1829), English; ophthalmologist to the English army and navy. Operations: 1. For cataract. 2. Formation of artificial pupil. 3. For ectropion. 4. Changing the position of the pupil.

Adams, William (1820-1900), English; surgeon, London. Operations: 1. For Dupuytrans contraction. 2. Subcutaneous osteotomy. 3. For deflected nasal septum. 4. Iliac colotomy.

Aëtius, Amidenus (500-550), Mesopotamian; physician and surgeon, Constantinople. Operations: 1. Scarification in anasarca. 2. Dilatation of os uteri with sponge tents. 3. Radical amputation of the breast for cancer. 4. Proximal ligation of an artery for aneurysm.

Affleck, (John G.)? American; Bridgeport, Ohio. Operation, embryotomy.

Agnew, Cornelius Rea (1830-1888), American; ophthalmologist, New York. Operations: 1. Excision of chalazion. 2. Destruction of the lacrymal sac. 3. Extraction of cataract.

Agnew, Davis Hayes (1818-1892), American; surgeon, Philadelphia. Operations: 1. Method of amputation. 2. Inguinal herniotomy. 3. Closure of salivary fistula. 4. For syndactylism.

Aikin, —? English; surgeon, Nottingham. Operation, excision of the superior maxilla.

Aitken, John (?-1790), Scotch; surgeon, Edinburgh. Operation, double pelviotomy.

Albarran, Joaquin (1860-con.), French; surgeon, Paris. Operations: 1. Vasectomy for prostatic hypertrophy. 2. Perineal total extirpation of the prostate.

Albert, Eduard (1841-1900), German; surgeon, Wien. Operations: 1. For flail knee-joint. 2. See Albert-Frank.

Albert-Frank's, q. v. Operation, method of gastrostomy.

Alexander, William (—-con.), English; gynecologist, Liverpool. Operations: 1. Prostatectomy. 2. Ligation of the vertebral arteries. 3. See Alquie-Alexander-Adams.

Allanson, Edward (1747-1828), English; surgeon, Liverpool. Operation, circular amputation at the shoulder-joint.

Allarton, George (1813-1875), English; surgeon, London. Operation, median perineal cystotomy.

Allingham, Herbert H. (1862-1904), English; surgeon, London. Operation, inguinal colotomy.

Allingham, William (1829-1908), English; surgeon, London. Operations: 1. Perineal proctectomy. 2. Method of excision of hemorrhoids. 3. Enterorrhaphy by aid of a bone-bobbin.

Allit, Oscar H. (— con.), American; surgeon, Philadelphia. Operation, method of reducing congenitally dislocated hip.

Alonette, —? Operation, amputation at the hip by a semicircular external flap.

Alquie-Alexander-Adams, q.v. Operation, advancement of the round ligament.

Alquie, Alexis Jacques (1812-1865), French; surgeon, Montpelier. Operation, see Alquie-Alexander-Adams.

Alsberg, Albert (1856-con.), German; surgon, Hamburg. Operation, for urethral stricture.

Amesbury, Joseph (1795-1864), English; surgeon, London. Operation, for pointed toe.

Ammon, Friederich August (1799-1861), German; ophthalmologist, Leipzig. Operations: 1. Blepharoplasty. 2. Destruction of the lacrymal sac. 3. Method of treating ectropion. 4. For symblepharon.

Amussat, Jean Zulema (1796-1856), French; surgeon, Paris. Operations: 1. Reinvention of angiostrophy. 2. Left lumbar colotomy. 3. For atresia ani. 4. Circular enterorrhaphy. 5. Dorsal hysteropexy. 6. For atresia vaginae. 7. Method of castration.

Anagnostaske, Andreas (1826-1897), Greek; ophthalmologist, Athens. Operations: 1. For entropion. 2. For trichiasis.

Anderson, Alexander Dunlop (1793-1871), Scotch; surgeon, Glasgow. Operation, excision of the inferior maxilla.

Anderson, William (1842-1900), English;

* Additions and corrections will be gratefully received.

surgeon, London. Operation, method of lengthening tendons.

Andrews, E. Wyllys (1856-con.), American; surgeon, Chicago. Operations: 1. Arthrotomy. 2 Herniotomy by the imbrication method. 3. Colohepatopexy. 4. Urogenital diaphragm destruction in prostatic ischuria. 5. See Andrews-Andrews.

Andrews-Andrews, q v. Operation, valvular gastrostomy.

Andrews, Edmund (1824-1907), American; surgeon, Chicago. Operations: 1. Gastrotomy. 2. See Andrews-Andrews. 3. See Rose-Andrews.

Anel, Dominique (1678-1730), French; army surgeon. Operations: 1. Ligation of an artery close to an aneurism and on the cardiac side. 2. Method of dilating the lacrymal duct. 3. Originator of the operation for aneurysm mistakenly attributed to John Hunter.

Angelucci, Arnoldo (1856-—), Italian; ophthalmologist, Palermo. Operation, method of extracting complicated cataract.

Anger, Theophile (—con.), French; surgeon, Paris. Operation. 1. For ingrown toe-nails. 2. For hypospadias. 3. Method of suturing divided tendon.

Angle, Edwar Harry (—-con), American; oral surgeon, St. Louis. Operations: 1. Double resection of inferior maxilla. 2. Method of treating fracture of the maxillary bones.

Annandale, Thomas (1830-1908), Scotch; surgeon, Edinburgh. Operations: 1. Osteotomy in genu valgum. 2. Fixation of displaced cartilages of the knee-joint. 3. Removal of naso-pharyngeal polyp by the palatine route. 4. For varicocele. 5. For syndactylism.

Antal, Geza (1846-1890), Hungarian; surgeon, Budapest. Operations: 1. Removal of tumor from urinary bladder. 2. Ligation of the ovarian arteries for uterine myoma.

Antyllus,—? (A.D. 3d or 4th century), Italian; surgeon. Operations: 1. Proximal and distal ligation of arteries for aneurysm. 2. Bronchotomy in threatened suffocation. 3. Radical operation for hydrocele. 4. See Antyllus-Kuhnt's.

Antyllus-Kuhnt. q.v. Operation, for paralytic ectropion.

Apostoli, Georges (1847-1900), French; electrotherapist Paris. Operation, electrolysis for uterine fibroid.

Appolito, —? Operation, enterorrhaphy by a right-angled continuous suture.

Archigenes, —? (81-117), Syrian; physician and surgeon, Rome. Operation, first amputation with ligation of vessels.

Argyll-Robertson (— con.), Scotch; ophthalmologist, Edinburgh. Operations: 1. For entropion. 2. For glaucoma. 3. For pterygium.

Arlt, Carl Ferdinand (1812-1897), German; ophthalmologist, Wien. Operations: 1. For symblepharon. 2. Median tarsorrhaphy. 3. For entropion. 4. For ectropion. 5. Lacrymal stricturotomy. 6. Blepharoplasty. 7. Enucleation of the eye. 8. For trichiasis. 9. See Arlt-Jaseches.

Arlt-Jaesches. q.v. Operation, transplantation of the ciliary bulbs for the cure of districhiasis.

Armsby, James (1810-1875), American; Operation, inguinal herniotomy.

Arnott, James (1794-1885)? English; surgeon, London. Operations: 1. Method of dilating urethral stricture. 2. Method of perineorrhaphy.

Asch, George Thomas (1729-1807), Russian; surgeon, St. Petersburg. Operation, correction of deflection of the nasal septum.

Asclepiades (?-96 B.C.), Greek; physician of Bithynia. Operations: 1. Laryngotomy. 2. Multiple puncture for dropsy. 3. Scarification of the fauces in acute diseases of the throat.

Ashton, Thomas John (—)? English; surgeon, London. Operation, for a congested and bleeding rectum.

Assalini, Paolo (1759-1840), Italian; surgeon, Mailand. Operations: 1. Formation of artificial pupil. 2. For iridodialysis.

Atlee, Washington Lemuel (1808-1878), American; gynecologist, Philadelphia. Operation, ovariotomy.

Aveling, James Hobson (1828-1892), English; surgeon, London. Operations: 1. Uranoplasty. 2. Direct transfusion.

Avery, John (1807-1855), English; surgeon, Mayfair. Operation, uranoplasty.

Avicenna, —? (980-1036), Arabian. Operation, the earliest reference to the employment of obstetrical forceps.

Ayres, Daniel (1823-1892), American; surgeon, New York. Operation, for ectopia vesicae.

(To be continued.)

It is just as ridiculous to announce lady physician, lady lawyer, lady preacher as it is to announce gentleman physician, gentleman lawyer, gentleman preacher. It is a strain on both sexes to announce female physician, female lawyer, female preacher; male physician, male lawyer, male preacher. We should have the good sense and grace to adopt the appropriate term—woman physician, woman lawyer, woman preacher, and man physician, man lawyer and man preacher.—Byron Robinson.

THE MEDICAL FORTNIGHTLY

Issued Tenth and Twenty-Fifth of Every Month.

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EDITORIAL

An Insult to Urologists.

In so far as we have ever been able to learn medical science looks on disease with an unprejudiced eye and draws little distinction among the various disorders of humanity laying stress only on the importance of alleviating human suffering and promoting human weal. To the scientific mind there is little distinction between the specialties, each has its right to a seat near the throne and its honors for what it has accomplished, and none has an exclusive claim for special honors and the right to wear the purple. The controversy being waged around the secretary-editor of the American Medical Association is not an especially edifying affair; it is deplored even by those who look on it as a necessity. But the most deplorable thing which has occurred in connection with it comes from the secretary-editor's adherents. There seems to have been no effort to refute the charges made in the case, dependence seeming rather to have been placed on laudation of the accused and mud-slinging at the accuser; the deplorable thing is that the mud which was meant for Dr. Lydston does him no harm, but thoroughly angers every member of the honorable specialty with which he has so long and prominently been identified. The temper of the offended urologists is well shown in the following letter which has been sent to those who are identified with this work throughout the country:

My Dear Doctor:

The following is an excerpt from an editorial appearing in the March issue of the Kentucky Medical Journal (A. T. McCormack, editor):

"So closely accompanying the action of the New York organization as to appear unconnected with it except to those who recognize the devious workings of the minions of the American Proprietary Association, there have appeared in the least reputable of the privately owned and nostrum supported press, simultaneous attacks on the life, character and work of our peerless national leader, Geo. H. Simmons. That the author of these attacks is a specialist in the filthiest of human diseases, seem to fit him for the degrading work assigned him and to those who know his personal spite and venom against the great editor of the Journal A. M. A., his impotence will be his excuse."

I am calling your attention to the foregoing as it is a vile and contemptible slur upon every member of the medical profession who specializes in urology. "A Specialist in the Filthiest of Human Diseases;" this expressiou was employed to throw mud at an individual, yet it slanders urology and not the individual, for the particular individual anonymously alluded to is exceedingly prominent and beyond any of the insinuations mentioned in the editorial. If urology as a specialty is classed as the "filthiest of human diseases," by the powers that be in the A. M. A., then the time is ripe for the urologist to assert himself individually and collectively.

The two great bodies, The American Urological Association and the American Association of Genito-Urinary Surgeons, should consider the matter very seriously. They should seek a proper recognition of their work and should force upon our great National Association the fact that urology is not a specialty of the "filthiest of human diseases," but one which has accomplished as great and far-reaching results in the field of medicine and surgery as any other specialty in medicine.

I am addressing you, doctor, for the purpose of placing this matter before every urologist of the country, and I consider it our duty to resent such an infamous and detestable attack upon the work of the genito-urinary surgeon.

Yours very truly,
LEWIS WINE BREMERMAN.

It is to be expected that the officials of the Kentucky Society and of the American Medical Association will fully appreciate the inexcusable character of the quotation, and will demand an immediate and complete apology from the editor of the Kentucky Medical Journal, or whoever was responsible for the utterance.

The Personal Factor in Disease.

That the personal equation in disease seems, at present, to be of more real importance in practice than anything else, is the opinion of Dr. Beverly Robinson (Med. Rec., Oct. 17, 1908). Formerly this was thought to be true, and the old time practitioner grouped people into classes, as of rheumatic, gouty, lymphatic, nervous, or bilious temperaments, and each of these he labeled a diathesis. These names meant more and differently then than they do today, but there was a kernel of great truth inherent in them. We know that individuals of the so-called rheumatic type, when exposed to wet, dampness or draughts, soon give signs of rheumatism. So is it with the gouty subject. Indiscretions in meat or drink, overwork or anxiety,

will bring on a swelling of the big toe. Numerous other illustrations can be cited. Aside from these clearly defined and evident dyscrasic conditions, there are many instances in which some accidental cause or other may bring out symptoms which make the underlying constitutional state probable, or even tolerably clear, In many individuals, however, there is no dyscrasia of any kind that can be shown, and yet they have pronounced peculiarities, idiosyncrasies, reaction to, or effect caused by, some special food or drink, or combination of different foods. Again, exercise, worry heat, tire of mind and body, may bring out symptoms in one individual and not at all in another. Medicines act very differently, and sometimes alarmingly in different patients, and frequently we have absolutely no means of knowing in advance why, or in what manner, they cause these occasional untoward and unexpected effects. Undoubtedly with time the body of man changes and changes, as we all know, to the effects of food, drink, medicine, etc. In view of these facts, we must believe that a wise, judicious empiricism in the way of caring for patients, in administering drugs, in trying to relieve symptoms, and perhaps cure disease, is thoroughly allowable and desirable, and this despite all of the advances and teachings of the more recent scientific methods of research. C. W. H.

The State Meeting.

This is our last opportunity to call our readers attention to the meeting of our State Association, which convenes at Jefferson City on the 18, 19 and 20 of this month. The State Journal in its issue recently received publishes the programs to be presented at the three sections and the splendid lists of papers should prove a tremendous attraction and insure a most profitable occasion. We notice with some regret that the large cities of the State seem to be in evidence on the program rather to the exclusion of smaller places; with the exception of the Medical Section few from outside the large cities have place among the essayists. In the scientific work of the entire meeting St. Louis men read about one-half the papers; this does not mean that there will be any fault to be found with the papers, quite the contrary, but it must prove unfortunate in the ultimate if men from the lesser cities are not encouraged to contribute and made to feel that they are something more than the audience. It is an exceptionally excellent program and promises a scientific feast.

The attendance at this meeting should be large; it is well worth whatever time and expense it occasions, and there are few members of the body who can afford to be absent.

The A. M. A. at Atlantic City.

In a little less than a month the greatest of medical organizations will be in convention at Atlantic City. Last year at the Chicago meeting Missouri did herself proud in the matter of attendance, and there is even greater reason for going it better this year. The expense for transportation is, of course, somewhat higher and the necessary absence from work occasioned is slightly longer, but the advantages of attendance so tremendously outweigh any consideration on the stay-at-home side that only those who have not attended need argument about it. Atlantic City at this time does not present all the attractions of a month later, that is the reason we go there, but it does offer an abundance of the best accommodation, a most hospitable welcome and a vast amount of amusement features which can be found nowhere else, and there will be an amount of scientific and social opportunity which will satisfy the most exacting.

Dr. W. S. Deutsch has removed his office to the Lister building, 4500 Olive street.

The tenth annual meeting of the St. Louis Medical Library Association was held on the evening of April 28th. Reports made at the time indicate that there is a steadily growing interest in the profession of the institution and that its field of usefulness is constantly widening.

Dr. Kenneth W. Millican, formerly of this city, now of Chicago, has lately donated his very valuable medical library to the St. Louis Medical Library and his extensive reprint collection to the collection of the St. Louis Medical Society. Both of these contributions are a mark of Dr. Millican's warm personal regard for the St. Louis profession and each is welcomed doubly in that it carries more than its intrinsic worth.

Dr. Bransford Lewis lately returned from attendance at the meeting of the South Carolina State Medical Association which was held at Summerville, April 20-22. Dr. Lewis and Dr. M. P. Ravenel, of Madison, Wis., were invited guests of the Association and delivered the principal addresses. Dr. Lewis reports that the South Carolina Association is a very vigorous body, full of enthusiasm and doing strong work.

THE REVIEWER'S TABLE

Books, Reprints, and Instruments for this department, should be sent to the Managing Editor, Century Building, St. Louis.

INTERNATIONAL CLINICS. A Quarterly of Illustrated Clinical Lectures and especially prepared Original Articles on Treatment, Medicine, Surgery, Neurology, etc. By leading members of the Medical Profession throughout the world. Edited by W. T. Longcope, M. D. Vol. III eighteenth series, 1908. Philadelphia and London: J. B. Lippincott & Co.

The third volume of this recognized publication embodies many elaborate and up-to-date articles. The section "Treatment" by Sir Duckworth, Paul Tissier and Almagia and Mendes, includes respectively, articles on sciatica, fluoroform in whooping cough and cholestrin in the treatment of tetanus. The section on "Medicine" embraces articles on typhoid perforation by J. A. Scott; esophagoscopy by M. Quisez; considerations of hysteria, by Tom Williams; and cytological examination of a case of malignant disease of the liver and spleen. Surgery is respectively represented by John Gibson and Duncan Despard who write on melanotic neoplasms; Eldred Corner, who writes an article on the treatment of fractures by direct internal splintage; George Muller, who contributes an article on adenoma of the thyroid gland; and H. S. Clogg, who writes on periodic inflammation. A. Schwab contributes an article "On the disinfection of the uterine cavity in puerperal infection," while J. H. Knox, Jr., and Richard Gilbert contribute to the section of Pediatrics. The subjects of Orthopedics, Neurology, Ophthalmology, Rhinology and Pathology are represented by men well fitted for the task. The volume is properly illustrated.

THERE is no doubt but that, in a considerable proportion of the cases of so-called habitual abortion, perimetritic adhesions of appendiceal origin lie at the bottom of the condition.—Everett O. Jones.

HOPE is the mainspring of life. It is the anchor that makes life worth living. Hope encourages the successful to greater achievements; it comforts the defeated; it is the flame of life. The lives of great men have been saturated with hope. The persistent hope of Columbus made the greatest discovery.—Byron Robinson.

CORRECTNESS of onomatology is even more an index of character in science than in daily speech.

In medical onomatology, as in ordinary speech, want of correctness is an offence against both truth and good manners.

Incorrect medical onomatology is on a par with slang in ordinary speech; the use of either betrays ignorance or a mind devoid of fine feeling.—A. Rose.

MEDICAL PROGRESS

Comprising the Regular Contributions of the Fortnightly Department Staff.

OBSTETRICS AND GYNECOLOGY.

W. H. VOGT, M. D.

Treatment of Uterine Displacements.—J. H. Baldy, M. D., Philadelphia (Surgery, Gynecology and Obstetrics, April, 1909), says that the time will come when men will be just as much ashamed to speak of retrodisplacements of the uterus as a distinct lesion as they are at the present so to speak and write of ascites. It is true that there are some cases in which it would seem that the retrodisplacement were the only thing which would explain the symptoms from which the woman suffered, but the more one sees of gynecologic practice the closer one is able to limit this list of exceptions. The rule is that retrodisplacements of the uterus are mostly coincident with other lesions, and where such is the case the symptoms almost universally come from the associated disease. "The treatment of retrodisplacements" is then a misnomer; it should be the "treatment of conditions in connection with which retrodisplacements of the uterus occur as an incident." In those cases in which no disease can be found, and again in those in which the disease found has been dealt with by appropriate treatment, and it is in addition desirable to bring a retrodisplaced fundus forward, Blady has been practising the following procedure for the last twelve years, and has found it highly satisfactory. The round ligaments are drawn around the posterior side of the uterus close to the top of the fundus. This is accomplished by perforating the broad ligaments immediately below the ovarian ligament. The round ligaments are then grasped with forceps, drawn through the opening in the broad ligaments and fastened together on the posterior surface of the uterus; they are then fixed to the uterus with a few extra sutures. When the round ligaments are adjusted and brought snugly together posterior, the ovarian ligaments rest on each round ligament and without so much as touching the ovarian or Fallopian tube, always and with absolute certainty insures the proper and safe elevation of those organs. It has been offered in criticism that the round ligaments will be stretched by the weight upon them, and that the weaker part of the ligament, i.e., the end toward the abdominal wall is the part which carries the whole weight. The author claims that the only failure to have performed the operation and ignorance of the mechanics can justify this criticism. The

operation has been performed by the author and his assistants almost 200 times, and he has personal knowledge of almost 30 pregnancies following the operations without the slightest irregularity. In no subsequently examined woman could it have been told in operation had been performed had it not been known.

The Treatment of Infected and Complicated Cases of Labor by Abdominal Section.—(Edward P. Davis, M. D., Philadelphia, Surg., Gyn. and Obstet., April, 1909.)—Ten cases of infected labor are described and the method of treatment in six cases was the Porro operation, in one the uterus tubes and ovaries were removed more than a year after the delivery by abdominal section. On 3 cases celiohysterectomy was performed—of these 10 cases, 7 lived and 3 died. Among these cases were 5 especially desperate cases in which efforts had been made to deliver by forceps, version and craniotomy. The author says that from a surgical standpoint the Porro operation is unsatisfactory; because it leaves a large mass to separate by sloughing, and exposes the patient to the inconvenience and delay of the process. It is however, quickly performed and patients escape general infection in cases which do badly when treated by other methods. The final result has in all cases been satisfactory. The pelvis has been left free from exudate, the stump of the cervix has been reduced to a small mass of tissue, which closes the vagina. The objection to the Porro operation is that it leaves the woman incapable of further child-bearing, but it is a question whether this class of cases should be exposed to further danger in the effort to bear children. Saving of the mother's life is as much as can be expected under the circumstances. The lives and health of the patients will be better preserved if the general practitioner will not attempt to apply the forceps when the head of the child does not engage.

Blood Pressure, Leucocyte Count and Ophthalmoscopic Examination in Diagnosis of Pre-eclamptic Toxemia.—(A. J. Skeel, Cleveland, O., Amer. Jour. Obstet. and Diseases of Women and Children, March, 1909.)—In this article Skeel reviews the literature very carefully and comes to the following conclusions: Albumin as a trace in the urine is of no value. It is present in a large proportion of cases of normal pregnancy. Albumin in considerable quantity, especially if increasing, is a strong indication of mischief. The entire absence of albumin is no proof that the woman is not toxic. Casts and diminished 24 hour quantity add to the value of the urinary findings. Specific gravity is of aid if the 24 hour quantity is known. Blood pressure findings taken by the fingers are of little or no value. The instrumental method must be used The blood pressure of pregnancy is normal until the last two months, when a slight rise occurs. This rise should not give a reading of over 150 m.m. The presence, over any period of a greater pressure than this should be considered a serious matter. During labor the pressure is somewhat elevated and quite variable, and is consequently not to be depended on. After labor the blood pressure should quickly drop to normal. In eclampsia the blood pressure is uniformly elevated, often to an extreme degree. In pre-eclamptic toxemia blood pressure is probably always elevated and is of diagnostic and prognostic importance. The fact that albumin and casts, with rise of blood pressure, may also be present in nephritis in no way detracts from their value here, because we know that with increasing albumin and increasing blood pressure in pregnancy, convulsions are imminent, regardless of whether or not we are able to distinguish the immediate cause of the patient's condition. The leucocyte count in eclampsia, and pre-eclamptic toxemia is increased 50 per cent and upward over the normal at the given period. When using the leucocyte count in the patients, care must be taken to exclude the leucocytosis of digestion, inflammation, hemorrhage, drugs, etc., and to remember the normal marked increase during and immediately following labor. One must also bear in mind the greater count normally present in primiparae as compared with multiparae, throughout pregnancy, labor and the puerperium In demonstrable ocular disturbances of early pregnancy, especially when accompanied by ophthalmoscopic lesions, evacuation of the uterus is indicated. In the latter two months of pregnancy these same lesions indicate a high grade of toxemia, but should be compared with the other findings to decide the treatment. The whole symptoms-complex should be carefully studied day by day, and as all the methods described are readily available in nearly every community, the general practitioner should have no difficulty in making use of them.

Endometritis.—G. Schickele (Beitage zur Geburtshilfe and Gynaekologie, xiiii, No. 3) speaks about the frequency with which the premenstrual congestion is often mistaken for endometritis, at the same time he presents evidence to prove the existence in some cases of glandular changes which are really pathologic and have nothing to do with the premenstrual congestion. Chronic congestion of the uterus from inflammation in the

adnexa lead to over-nourishment of the glands, and they become hypertrophied and functionate to excess, increasing the discharge. The menstrual flow comes on earlier and lasts longer than normally and may become irregular. Curettement fails to benefit in this class of cases, or has merely a transient effect; if the primary trouble is not cured the same sequence of disturbance will occur again later. Schickele emphasizes the fact that the change in the mucosa observed in many conditions of chronic inflammation in the adnexa with uterine displacements and with general vasomotor disturbances are in reality secondary.

Injection of Broad Ligament with Quinine for Prolapsed Uteri.—(J. I. Parson, Practitioner, London, March.)—Having observed that subcutaneous injections of quinine in malaria produced effusion and caused a swelling that remained for months, it occurred to the author to try the effect of irritating the cellular tissue of the ligaments with quinine, so as to produce an effusion of lymph that should form new connective tissue. The technic is described as follows: Before the operation is performed, the bowels are thoroughly cleaned out and the vagina douched with a 1 to 2,000 solution of perchloride of mercury. An anesthetic is advisable, although the operation takes but a few minutes. A bladder sound is passed and the extent to which it falls down on each side of the uterus is noted. A Sims speculum is then inserted, to hold up the anterior vaginal wall; it should be wide enough to draw the bladder well up and out of the way. A straight sound is then passed into the uterus and held horizontally by the left hand of the operator, while the syringe containing the solution is held in the right hand. The injection is made with a needle one inch long on each side of the uterus through the vaginal wall at a distance of three-fourths of an inch from the cervix, and a little below the level of the external os. If the cervix is enlarged, which oftens happens in prolapsus, the point of injection should be nearer to the cervix. The aim of the operator should be to insert the needle exactly half way between the position of the normal cervix and the pelvic wall; then the nearest portion of the uterine artery and veins and the ureter lie to the right of the needle and above it. Another point is that, in the outer half of the broad ligament in this situation, there are no veins of importance. In cases of chronic procidentia, it is advisable to inject somewhat lower, on account of the tendency of the bladder to pouch down on each side of the cervix. The needle is apt to be corroded by the acid in the solution, and should therefore be tested before use, and thoroughly washed out afterwards in warm water. A cup and stem rubber vaginal pessary is then inserted, and secured by tapes to a band around the waist. After three days it may be removed. The patient is instructed to lie on her face or side as much as possible. The bowels should be kept open every day, but free purging must be avoided. Cinchonism is rare. The exact solution is 12 grains of the ordinary sulphate of quinine, dissolved in 30 minims of distilled water. It should be made fresh for each patient. As the space on the left side is encroached on by the rectum, he usually injects 10 minims less on that side than on the right. Repair of the perineum if necessary, adds very considerably to the comfort of the patient and also helps the ligaments. Taking all the easiest cases and also the most difficult, the latter forming by far the larger proportion, and including a great many cases of chronic procidentia, Parsons find that in 75 per cent the uterus has kept up permanently, 20 per cent were greatly improved, and in 5 per cent the measure failed.

GENITO-URINARY.

T. A. HOPKINS, M. D.

The Surgery of Syphilis.—G. F. Lydston, Chicago (Jour. A.M.A. Feb. 20), emphasizes the fact that many practitioners treat syphilis too specifically and that in many cases radical surgical measures are the primary indication, specific medication taking almost a secondary position. The initial lesion rarely requires the knife, save in case the duration is very persistent and defies specific treatment for a long period. Here a clean incision is sometimes of great advantage, and the more thoroughly the patient has been previously treated with mercurials, the less chance of a recurrence. The most frequent call for surgery in primary syphilis is in hidden chancre or mixed sore with phimosis. He has long since given up all hesitation in such cases, the chances of wound infection being almost negligible as compared with those of allowing the lesion to progress without diagnosis or proper treatment. In his own experience he has never had occasion to regret making a dorsal incision of the prepuce for the purpose of freeing the glans and inspecting and treating the concealed lesion. Marked edma occurring with chancre sometimes demands multiple punctures, and this is preferable in persistent cases to permitting the edema to be followed by connective tissue hyperplasia

calling for the knife later. In mixed sores and superadded pus infections in true chancre, abscesses may occur in the course of the lymphatics of the penis, which, of course, call for incision. It is hardly necessary to say that the syphilitic bubo, per se, needs no surgery, but when there is chancroidal or tuberculous infection the knife is called for. Lydston here pleads for thorough extirpation of the glands in such cases; halfway measures are not effective, according to his experience. The surgery of secondary syphilis is still more limited. Induration after edema may call for it and obstinate mucous patchs and ulcers may do well under light curettement. Various conditions of the jaws and teeth have an important relation to these lesions and call for surgical treatment. It is in late uncured syphilis that surgery becomes of more and more importance in the treatment. The same indurating edema noticed above is often encountered in broken-down subjects of tertiary syphilis. Extensive tumors about the genitals may thus result and may persist long after the luetic infection is under control, and should be dealt with just as any other new growth would be. The mistake is often made of trying to cause their disappearance by specific treatment; they are no longer syphilitic, but are merely the results of syphilis. Gumma in certain situations should be treated surgically more frequently than is the custom. Lydston holds that obstinate gumma of the brain, resisting internal medication, and when accurate localization is possible, is one of these conditions. The same is true of stubborn gummy ulcers which are likely to heal after the indurated base is cut away, always provided that the constitutional treatment has been judiciously carried out. Syphilitic bone disease is the cause of more barbarous specific overdosing than any other lesion occurring in syphilis, and many cases of caries and necrosis are the result. Mercury and iodid must, of course, be the mainstay in the constitutional treatment, but the local condition must be treated on its merits as if it were due to other causes than syphilis. Lastly Lydston calls attention to the frequency with which gummata and obstinate ulcers of the tongue are replaced by malignant disease. In such cases the diagnosis is often delayed and the patient continues to be dosed with iodid and mercury to his damage. Lydston has observed a large number of such cases in which the opportunity for the cure of the disease by surgery has been lost. He thinks that the profession as a whole, is woefully unobserving in this class of cases. He has, he says, arrived at the point where, when the microscope is guessing, he is perfectly willing to hazard his reputation by playing the only surgical trump at his command and removing the tongue. Operations on syphilitic patients, he says in whom the constitutional disease is under fair control by specific medication, are likely to result in primary union of the wound just as though syphilis did not exist. In clean aseptic incised wounds repair will occur quite as rapidly as in non-syphilitic subjects. In open wounds, or in chronic non-specific lesions occurring in syphilitics, where irritation is marked and persistent, the syphilitic constitution undoubtedly delays repair, and the rational use of mercury and iodids is an indispensable adjuvant.

On the Use of the Wax-Tipped Catheter for Diagnosis of Kidney Stone in the Male.—When, as sometimes happens, the X-ray fails to show the presence of calculus, a resort to the wax-tipped catheter may give positive evidence of stone. From a paper under the above title by Winfield Ayers (Am. Jour. of Surgery, Nov., 1908) we give a brief description of this instrument and its appilcation. The only instrument now made that can be usd for this purpose is Brown's old model—the one with the projecting telescope. The author has added to this model a special telescope for the wax-tipped catheter. For coating the catheter Kelly uses one-half olive oil with one-half dental wax, but the author prefers beeswax. This is soft enough to receive the impression of a calculus and is harder than Kelly's mixture and more easily handled. Four catheters should be prepared before insertion of the cystoscope. The catheter is threaded through the catheter-chamber backwards, until only the tip projects beyond the telescope and is placed on the table with the tips projecting over the table edge. The cystoscope sheath is passed and the bladder washed out through it; then the bladder is filled. The telescope with the catheter in place is passed through the sheath while the water is flowing from the bladder, the sheath being somewhat depressed so as to throw the telescope when it emerges from the sheath well up; then more water is put in the bladder. If care has been taken with the passage of the telescope, and if the catheter has been rotated so that the tip will be just in front of the lens, the tip will not have touched the sheath at all, and when the bladder having been filled, and the light turned on, the tip inspected through the cystoscope, will be seen to be perfect. The catheter is now inserted in the suspected

ureteral orifice and slowly passed. If any tender area be detected, its distance from the bladder should be located and then the catheter withdrawn and inspected. Or it may be passed to the renal pelvis before encountering any obstruction or tender area. The impression of a calculus on the wax may be a very slight scratch or what is more usual a deep gouge. The very slight scratch requires corroboration by other similar scratches, but the deep gouge is positive evidence of the presence of a stone. Impression by solid tissue is smooth and differs materially from that of a stone. However, a flattening out of the tip of the catheter requires several tests to prove that the substance is not the face of a calculus.

BYRON ROBINSON'S NOTE-BOOK.

Reno-ureteral tuberculosis is a secondary process.

The sovereign remedy (at present) for reno-ureteral tuberculosis is nephrectomy.

Nephrotomy has not proved satisfactory in reno-ureteral tuberculosis.

Nephrotomy may serve the purpose of a preparatory aid to nephrectomy by draining extensive renal abscesses and infected areas.

Bilateral reno-ureteral tuberculosis is not a contra-indication to nephrectomy, if one kidney be able to assume the necessary function of both.

I saw a specimen from autopsy which demonstrated carinoma of the left ureter which shortened the ureter to four inches and obliterated its lumen.

I have collected 26 sigmoid kidneys. They are dangerous kidneys for hasty surgeons.

Recently two surgeons removed one a piece which was fatal, because the patients possessed but one each.

The sigmoid kidney jeopardizes the patient in gestation, parturition and defecation.

Much comes to one who works while waiting.

Nicholas Senn was the greatest medical man of my observation.

Gynecologic curettage should be performed for diagnosis only.

I saw Billroth perform nephrectomy for a beautiful transparent renal cyst in 1887. He said, "Ich habe die Niere geschnitten da her Muss ich die Niere ausnehemen." What would that operation be called in 1907, two decades later? It would be called malpractice.

In 1884 I saw Prof. Czerney attempting to diagnose an abdominal swelling in a woman very ill. He said "Meine Herren ich kan die Diagnose nicht machten." The next day he operated on the woman removing an immense grayish black ovarian tumor. He then said gangrene. However he did not recognize the etiology. It was an ovarian tumor rotated on its pedicle. The woman died.

It required the great genius of Lawson Tait to tell the whole story of tumors rotating on their axes a few years later. While Tait's pupil in 1891 I saw four subjects with abdominal tumors rotated on their pedicles.

The diagnosis of pancreatitis is almost always made on the autopsy table.

The proximal ureteral isthmus averages one-twelfth of an inch in diameter. The middle ureteral isthmus averages one-seventh of an inch and the distal ureteral isthmus averages one-tenth of an inch. Ureteral isthmuses obstruct calculus.

Trauma of the psoas muscle is the general etiology for perityphlitis producing peritoneal adhesions in the meso-appendix which compromises the appendicular vessels, flexes the appendix checking appendicular drainage.

Trauma of the psoas produces 80 per cent of mesosigmoiditis in adults.

LATENT malignant disease of the stomach is often not recognized on account of the absence of pain.—Stern.

THE gold-beaters of Berlin at a Paris Exposition showed gold leaves so thin that it would require 822,000 to produce the thickness of a single inch, yet each leaf was so perfect and free from holes as to be impenetrable by the strongest electric light.

SPECIAL TRAIN SERVICE TO THE A. M. A.—The "Missouri Valley and Southwest" special will leave St. Louis Saturday noon, June 5, via the Big 4 and C. & O. railways, running through solid to Atlantic City, arriving there early Monday, in ample time to attend the sessions of the House of Delegates and the auxiliary meetings. Rate will be one and one-half fare for round trip. Party will stop over Sunday at Hot Springs, Va., where a complimentary dinner will be served by Mr. Sterry, manager of the Homestead. Everyone invited to join the party. Full particulars and itinerary may be obtained from the secretary, Dr. Chas. Wood Fassett, St. Joseph, or of the editor of the FORTNIGHTLY.

TO THE FRONT SAINT LOUIS

THE MEDICAL FORTNIGHTLY

A Cosmopolitan Biweekly for the General Practitioner

The Medical Fortnightly is devoted to the progress of the Practice and Science of Medicine and Surgery. Its aim is to present topics of interest and importance to physicians, and to this end, in addition to a well-selected corps of Department Editors, it has secured correspondents in the leading medical centers of Europe and America. Contributions of a scentific nature, and original in character, solicited. News of Societies, and of interesting medical topics, cordially invited.

Advertising forms close on the first and fifteenth of each month. Time should be allowed to submit proof for correction. Advertising rates on application.

Remittances and business communications should be addressed to the Fortnightly Press Co.

Subscription, $2.00 a year, in advance, including postage to any part of the United States, Mexico and Canada. Postage to foreign countries in the Universal Postal Union, including Newfoundland, $1.00 a year additional. Entered at the St. Joseph postoffice as second-class matter.

Subscriptions may begin at any time; volumes end with June and December.

Contributors should understand that corrected typewritten copy is essential to clean proof and prompt publication, and is much more satisfactory than manuscript. Original articles should be as condensed as justice to the subject will allow.

Editorial offices in St. Louis and St. Joseph, where specimen copies may be obtained, and subscriptions will be received.

Contributions and books for review should be addressed to the Managing Editor, 319 and 320 Century Building, St. Louis, Mo.

MEDICAL MISCELLANY

A MERITED HONOR.—So great is San Francisco's rejoicing over the successful fight made there to stamp out the dreaded bubonic plague, that a grand banquet was given on March 31 in honor of Passed Assistant Surgeon Rupert Blue of the United States Health and Marine-Hospital Service.

APPOINTMENTS AT THE ROCKEFELLER INSTITUTE.—At a meeting of the Board of Directors of the Rockefeller Institute for Medical Research, held on April 10, the following promotions and appointments were made: Associate Members, John Auer (Physiology), Hideyo Noguchi (Pathology), Alexis Carrel (Surgery); associate, George W. Heimrod (Chemistry); assistants, Martha Wallstein (pathology), Richard V. Lamar (pathology), A. O. Shaklee (Physiology), Gustave M. Meyer (Chemistry); Fellows, M. T. Burrows (Pathology), Paul F. Clark (Bacteriology).

THE pulse tells more than the thermometer to the skilled diagnostician in the course of an attack of appendicitis.—Medical Standard.

AMERICAN MEDICAL EDITORS' ASSOCIATION.—The coming meeting of this association, which will be held at the Marlborough-Blenheim, Atlantic City, will celebrate the fortieth anniversary, and a good program has been prepared for the occasion. It is expected that delegates from the foreign medical press will be present, and it is hoped that every medical editor will make an effort to be present at the meetings.

A LARGE MEDICAL LIBRARY.—According to the annual report of the Library Committee of the College of Physicians and Surgeons, Philadelphia, for 1908, the number of volumes in the library is 77,603; general library, 60,562; Lewis library, 13,515; S. D. Gross library, 3309; Obstetrical Society library, 217. There are also unbound "reports" and "transactions," 9115; unbound "theses" and "disertations," 22,681 unbound pamphlets, 67,122.

THE CANADIAN ASSOCIATION FOR THE PREVENTION OF TUBERCULOSIS will hold its ninth annual meeting in Hamilton, Ont., on May 19th and 20th, under the patronage of His Excellency the Governor General. The local arrangements are in the hands of a committee appointed by the Hamilton Health Association, who have prepared an interesting program and have made arrangments for the entertainment of the visiting members and their friends. Among the speaker will be Dr. George J. Adami, of Montreal, and Dr. William C. White, of Pittsburg, Pa.

THE AMERICAN PROCTOLOGICAL SOCIETY.—Eleventh annual meeting in Atlantic City, N. J., on June 7th and 8th. The headquarters and place of meeting will be at Haddon Hall, and the medical profession is invited to attend the sessions. The programme includes twenty-six papers on subjects relating to proctology by well kown specialists in that branch of medicine, and the meeting promises to be both interesting and instructive. Further information regarding the meeting may be obtained from the secretary of the society, Dr. Lewis H. Adler, Jr., 1625 Arch Street, Philadelphia. Dr. George B. Evans, of Dayton, Ohio, is president, Dr. John L. Jelks, of Memphis, Tenn., is vice-president, and the executive council consists of the following members: Dr. A. Bennett Cook, of Nashville, Tenn., chairman; Dr. George B. Evans, of Dayton, Ohio; Dr. Samuel T. Earle, of Baltimore; and Dr. Lewis H. Adler, Jr., of Philadelphia.